AMENDED IN ASSEMBLY MAY 8, 2003

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL No. 801

Introduced by Assembly Member Diaz
(Coauthors: Assembly Members Leiber and Yee)

February 20, 2003

An act to add Article 10.5 (commencing with Section 2198) to Chapter 5 of Division 2 of the Business and Professions Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 801, as amended, Diaz. Cultural and linguistic competency of physicians.

Existing law requires the Division of Licensing of the Medical Board of California to establish continuing medical education requirements for physicians and surgeons and to administer other specified programs.

This bill would enact the Cultural and Linguistic Competency of Physicians Act of 2003~~. The~~ *where local medical societies of the California Medical Association, while monitored by the* division, would ~~administer~~ *operate* a voluntary *competency* program for physicians. The program would develop educational classes to teach foreign languages to interested physicians and would offer classes designed to teach physician participants about cultural practices and beliefs that impact health care. The bill would require the formation of a work group to examine and recommend whether successful participating physicians receive credit for the program *and to establish standards for courses and training*. The bill would require funding of the program by fees charged to physicians who elect to take the

educational classes and by any other funds secured by local medical societies.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) From July 1990 to July 1999, inclusive, California's population increased by approximately 4 million people. Approximately 61 percent of this growth can be attributed to the growth in the Latino population.

(b) Title VI of the Civil Rights Act of 1964 requires any federally funded health facility to ensure persons with limited English proficiency may meaningfully access health care services. Persons with limited English proficiency are often excluded from programs, experience delays or denial of services, or receive care and services based on inaccurate or incomplete information.

(c) The Association of American Medical Colleges in 1998 found only 6.8 percent of all graduates from the United States medical schools were of an ethnic or racial minority group.

(d) According to the Institute of Medicine report requested by the United States Congress, research evidence suggests that provider-patient communication is directly linked to patient satisfaction and subsequent healthy outcomes for patients. Thus, when sociocultural differences between the patient and the provider are not appreciated, explored, understood, or communicated in the medical encounter, the result is patient dissatisfaction, poor adherence, poor outcomes, and racial and ethnic disparities in health care.

(e) The Summit on Immigration Needs and Contributions of the Bridging Borders in the Silicon Valley Project found that approximately 50 percent of participants reported that having a provider that speaks his or her language will improve the quality of health care services they receive.

(f) In its April 2003 report to the Legislature, the State Task Force on Culturally and Linguistically Competent Physicians and Dentists found that "our cultural beliefs impact and shape our beliefs about health care and the health care delivery system.

Because health care providers frequently do not understand unique cultural beliefs about health care that many consumers hold, and do not consider culture when developing a treatment plan, many consumers are given treatment regimens that they will not follow. As a result, it is more important than ever that health care providers possess a degree of cultural competency that they bring to interactions with their patients."

SEC. 2. Article 10.5 (commencing with Section 2198) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 10.5. Cultural and Linguistic Competency of Physicians Act of 2003

2198. (a) This article shall be known and may be cited as the Cultural and Linguistic Competency of Physicians Act of 2003. The cultural and linguistic physician competency program is hereby established and shall be ~~administered~~ *operated by local medical societies of the California Medical Association and shall be monitored* by the Division of Licensing of the board.

(b) This program shall be a voluntary program for all interested physician members and nonmembers of the California Medical Association and local medical societies. The program shall consist of educational classes designed to teach a foreign language and cultural practices and beliefs to interested physicians ~~which impact health care to persons whose language and culture are not the dominant culture in California.~~. *As a primary objective, these classes shall strive to teach physicians a foreign language at the level of proficiency that initially improves their ability to communicate with non-English speaking patients and eventually enables them to communicate directly with their patient population. In terms of culture, the primary objective is to teach physicians cultural beliefs and practices that impact patient health care practices and allow physicians to incorporate this knowledge in the diagnosis and treatment of patients who are not from the dominant culture in California.*

(c) The program shall operate through local medical societies and shall be developed to address the ethnic language minority groups of interest to local medical societies.

(d) In dealing with Spanish language and cultural practices of Mexican immigrant communities, the cultural and linguistic training program shall be developed with direct input from physician groups in Mexico who serve the same immigrant population in Mexico. This is the standard approach for any of the languages and cultures that is taught by the program.

~~(3)~~

(e) Training programs shall be based and developed on the established knowledge of providers already serving target populations and shall be formulated in ~~conjunction~~ *collaboration* with the California Medical Association, the board, and other ~~interested parties~~ *California-based ethnic medical societies.*

(f) A work group shall be established under the auspices of the board to ~~examine~~ *:*

(1) Examine and recommend whether credit may be given to physicians who enroll and successfully pass training modules or who complete program development. This credit may be in terms of receiving increased reimbursement rates under Medi-Cal, the Healthy Families Program, and health maintenance organizations. Standards shall be established to determine the degree of competency and reimbursement enhancements.

(2) Establish standards for cultural and linguistic competency courses and training to ensure they are consistent with the intent of this article, have a practical application and academic merit, and are accredited by the Accreditation Council for Continuing Medical Education.

(g) Funding shall be provided by fees charged to physicians who elect to take these educational classes and any other funds that local medical societies may secure for this purpose.

(h) A survey for language minority patients shall be developed to measure the degree of satisfaction with physicians who have taken these educational classes on cultural and linguistic competency. Another survey shall also be developed for instructors of cultural and linguistic educational classes to assess physicians beyond grades given for course work.

2198.1. For purposes of this article, "cultural and linguistic competency" means cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including, but not limited to, the following:

(a) Direct communication in the patient-client primary language.

(b) Understanding and applying the roles that culture, ethnicity, and race play in diagnosis, treatment, and clinical care.

(c) Awareness of how the health care providers and patients attitudes, values, and beliefs influence and impact professional and patient relations.

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